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COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Twenty-second session

SUMMARY RECORD OF THE 18th MEETING

Held at the Palais Wilson, Geneva,
on Monday, 8 May 2000, at 10 a.m.

Chairperson: Ms. BONOAN-DANDAN

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GE.00-41970 (E)

The meeting was called to order at 10.10 a.m.

SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (agenda item 3) (continued)

Draft general comment No. 14 on the right to the highest attainable standard of health (art. 12 of the Covenant) (HR/CESCR/2000/NONE/6) (continued)

1. Mr. RAMCHARAN (Deputy High Commissioner for Human Rights) said that ever since the adoption of the Universal Declaration of Human Rights, the organs of the United Nations had concerned themselves with the concrete application of the economic, social and cultural rights set forth therein. The International Covenant on Economic, Social and Cultural Rights provided that States parties must take legislative and other measures to achieve the full realization of the rights recognized therein, without discrimination of any kind. In addition to those two obligations, binding with immediate effect, States were required to establish follow-up machinery to secure the realization of those rights. There must be cooperation at international level, and the Economic and Social Council was responsible for coordinating the efforts of States and specialized agencies.

2. Regrettably, debates on human rights too often tended to be confined to affirmations of worthy intentions and pious hopes, which were not sufficient to ensure the exercise of those rights. He therefore welcomed the adoption of general comments by the Committee, and its consideration of the draft general comment on the right to health, which constituted a contribution to the concrete implementation of the rights concerned. A State party must demonstrate, not only that the right to health, for example, was recognized in its national legislation, but also that the competent administration was monitoring the realization of that right and that remedies were available where appropriate. The human rights community, States, non-governmental organizations (NGOs) and specialized agencies must be able to identify concrete measures to ensure the exercise of the right to health.

3. Mr. RIEDEL (Rapporteur for draft general comment No. 14) introduced draft general comment No. 14 on the right to the highest attainable standard of health (art. 12 of the Covenant). The preliminary draft text, which he had prepared with the assistance of Jakob Schneider and Christina Klee, had been examined, under the direction of Mr. Tarantola, by a number of World Health Organization (WHO) experts. He wished to thank Helena Nygren-Krug and Steven Olejas for their valuable assistance in that work. His thanks also went to Philippa Bergin, Gian-Luca Burci, Binod Mahanty, Fernando Gonzalez Martin, Hans V. Hogerzeil, John Martin, Maristela Monteiro, Nafsiah Mboi Andi, Winnie Mpanju-Shumbusho, R. Pararajasegaram, Mary Petevi, Geneviève Pinet, Sylvain Poitras, Margaret Reeves, Sonal Sena, Marcus Stahlhöfer, Nicole Valentine and Daniel Wikler. The first version of the draft general comment, based on those discussions, had been circulated on 23 March 2000 and substantially revised since that date. He also wished to express his gratitude to Audrey Chapman, Maria Green and Brigit Toebes for their valuable assistance. Thanks were also due to Eltje Aderholt, Patricia Aguilar, Judith Asher, Ana Barrios, Christian Benn, Marie Isabel Bertone, Andrew Clapham, Fons Coomans, Anne Deschamps, Greg Elder, Adriaan van Es, Peter Hall, Bernie Hamilton, John Havard, Marianne Haslegrave,

Aart Hendricks, Chris Jochnick, George Kent, Eve Lester, Steven Marks, Jean Martin, S.K. Mishra, Javier Mujica, Naomi Onega, Victoria Pinkney-Atkinson, Jayesh Rathod, Len Rubinstein, Robert Varenik, Sarah Zaidi, Constance Thomas (ILO), Kishore Singh (UNESCO) and Julian Berger (Office of the United Nations High Commissioner for Human Rights). Lastly, he thanked the secretariat and the members of the Committee, particularly those on the Drafting Committee.

4. He had not wished to redefine the right to health, which was a matter for the States parties, but rather to interpret the provisions of article 12 (1) and (2) of the Covenant dynamically, so as to build on the obligations described therein. Such an approach was facilitated by the structure of article 12: paragraph 1 comprised a general, relatively abstract provision, which was then spelled out in more detail, though not exhaustively, in subparagraphs (a) and (d) of paragraph 2. He had thought it best not to tackle new aspects of the right to health concerning, for example, biotechnology or organ transplants, which were dealt with by specialized agencies and which might perhaps warrant the drafting of new treaties. The draft general comment dealt with the normative content of article 12 (in part I), States parties' obligations (part II), violations of the right (part III), implementation of the right at the national level (part IV), and obligations of actors other than States parties (part V). The introductory paragraphs contained a short definition and a historical overview of the right to health, together with a reference to the indivisibility of all human rights. Part I defined all aspects of the right to health and the underlying determinants of health, emphasizing the quality of health services. In part IV, the paragraphs on health indicators and benchmarks had been condensed and rewritten. Lastly, it had been decided not to draw up a list of key indicators, pending the results of the work of WHO on that subject.

5. The CHAIRPERSON said that a former member of the Committee, Mr. Alvarez Vita, was also to be thanked for his contribution.

6. Mr. TARANTOLA (World Health Organization) said that WHO was currently drawing up a strategy to incorporate human rights in its activities and that there was therefore a synergy between his organization's approach and that of the Committee. The draft general comment made judicious use of the experience acquired in recent decades, which had facilitated determination of the requirements for complementary action in the spheres of health and human rights. At the practical level, health workers must define a process for the protection of human rights. That required, inter alia, modifying WHO's objectives so as to base them on human rights principles.

7. The definition of health contained in the WHO Constitution ("a state of complete physical, mental and social well-being") differed from the one set forth in article 12 of the Covenant, from which the social aspect was omitted. However, many other articles of the Covenant dealt with social well-being. Moreover, article 2 of the Covenant referred to certain limitations, including the progressive nature of the steps to be taken by States parties to achieve the full realization of the rights recognized. Accordingly, States could limit the implementation of human rights without infringing them, provided that the decision-making process concerning that limitation was an appropriate one. For example, it was acceptable to restrict freedom of movement in the event of an epidemic. That also explained why health practitioners often saw human rights as an obstacle to their work, failing to understand the "value added" represented by

human rights, and were unaware of the procedures to be followed when public health requirements justified imposing restrictions on human rights. They should thus be provided with specific training in that field.

8. The task of establishing indicators was particularly difficult because of the enormous gap between developed and developing countries. Consequently, indicators must not only make it possible to determine a minimum standard of health, but must also encourage States progressively to adopt more ambitious objectives as their economies developed. While most industrialized countries had fulfilled their commitments concerning the right to health, in some cases the situation was less than satisfactory. That was also true of the developing countries, but it would probably be counterproductive to stress that the latter were at a disadvantage.

9. The promotion of health was not mentioned in the Covenant, which had been drafted more than 10 years before the 1978 Alma Ata International Conference on Primary Health Care, devoted to that topic among others. The inclusion of that aspect of the matter in the draft general conclusions was thus to be welcomed.

10. For a considerable time WHO had been compiling data to be used in establishing indicators, but they could not be used to make comparisons either between countries or over a given period of time in any one country. Moreover, the indicators lacked refinement, as they represented national averages and were not broken down by social groups. Consequently, for the past two years WHO had been designing composite indicators, which were to be established on the basis of systematically compiled data and periodic or ad hoc survey findings. Experimentally, WHO had used several types of indicator concerning the life expectancy of persons in good health; inequalities and discrimination in health matters; the level of respect, in the health system, for the dignity, privacy and independence of patients (an indicator combining health and human rights requirements); and respect for the principle of participation in health-care financing based on individual means. The task of designing and implementing those indicators would be complex, and the Committee had been wise to decide to wait for WHO to complete its works before taking a decision on the matter.

11. The CHAIRPERSON invited the Deputy High Commissioner for Human Rights to comment on the points raised by the WHO representative.

12. Mr. RAMCHARAN (Deputy High Commissioner for Human Rights) commended the pragmatism of the indicators WHO was in the process of preparing. However, they did not address the important issue of human rights in health management. That concern should find expression, if not in an indicator, at the very least in a set of criteria. It would also be helpful if general comments began with a summary of the steps to be taken by States.

13. The CHAIRPERSON said that the WHO representative's observation concerning the need to expand the field of application of article 12 was highly pertinent and underscored the indivisibility of human rights. The progressive nature of the steps to be taken and the possible limitations on rights had given rise to disputes which had been cited by some States parties as justification for non-compliance with the Covenant, or even outright violation. Lastly, the indicators described by the WHO representative would be very helpful to the Committee.

14. Mr. SADI suggested that the Committee might also address some of the issues raised by new technologies, such as genetic engineering and cloning.

15. Mr. TARANTOLA (World Health Organization) replied that it would be useful to look into the impact of medical research on human rights. More generally, epidemiological studies, for instance, might violate human rights, especially if they failed to respect privacy.

16. Mr. MARCHÁN ROMERO said that the relatively widespread privatization of the health system raised major problems, particularly in the developing countries, since States might stop ensuring respect for the right to health and, more particularly, might no longer be able to guarantee access to health care for the entire population. That being so, where must the line between the public and private sectors of the health system be drawn so that the State could continue to fulfil its obligations towards the population?

17. Mr. ANTANOVICH asked Mr. Tarantola whether WHO intended to create a structure responsible for human rights and what consultation and cooperation links there could be between that structure and the United Nations treaty bodies. Did WHO think that States' fundamental obligations were sufficient, or that, on the contrary, they hindered provision of a full range of health services?

18. Mr. GRISSA said that today's borders were open and were crossed by millions of tourists and refugees. Epidemics did not respect borders, nor did pollution, as was attested by various nuclear and chemical accidents. What was the State's responsibility in that regard? For example, was Egypt responsible for the mines planted on its territory during the Second World War?

19. Mr. TARANTOLA (World Health Organization), replying to a question on States' propensity to delegate their responsibilities and their authority to private entities, said that WHO had set up a committee to examine the impact of globalization-related phenomena on health. While it was true that, in delegating their responsibilities to private entities belonging to multinational networks, States promoted better health service provision, they simultaneously created new risks, the full extent of which had not yet been assessed. That was a thorny problem that called for more extensive research, owing to the many factors that remained unknown: for instance, no one could say whether the private sector would prove a more efficient health-care provider than the public sector. What was certain, however, was that if globalization was not backed up by safety mechanisms, the population would suffer more than before. A State could delegate its responsibility for the provision of services, but not its responsibility for ensuring that no individual was economically marginalized.

20. As to the interrelationship between health and human rights, WHO was aware that those were cross-sectoral topics and had set up an administrative unit with a large staff responsible for coordinating all relevant activities. The unit received funds allocated from the regular budget, as well as extrabudgetary resources from donors such as Norway. WHO intended to continue its cooperation in that area with the Office of the United Nations High Commissioner for Human Rights.

21. States' fundamental obligations enumerated in the draft general comment would soon lose their relevance for many countries. Indeed, the process of defining governmental obligations was as important as the actual outcome, if not more so. In other words, health priorities were less important than the processes whereby they were defined by governments, with the involvement of all interested parties and with reliance on data collected, analysed and processed with full respect for human rights.

22. The supranational nature of certain public health problems had been recognized by WHO, as was attested by the anti-AIDS campaign. Child immunization programmes had likewise underscored the need for international financial and technical solidarity. Worldwide health initiatives could not produce results unless rich and developing countries alike understood their respective obligations and agreed to combine their efforts. The Chernobyl nuclear accident had demonstrated the importance of a multiple partnership between polluting and affected countries.

The meeting was suspended at 11.35 a.m. and resumed at 11.50 a.m.

23. The CHAIRPERSON invited the representatives of the United Nations specialized agencies and the non-governmental organizations to comment on the draft text, after which the Committee would examine it section by section.

24. Ms. CASSAM (United Nations Educational, Scientific and Cultural Organization - UNESCO) said that the Committee, in drafting a general comment on the right to health one year after dealing with the right to education, enabled the entire United Nations system to gauge the importance of economic, social and cultural rights. There had been many changes in the 40 years that had elapsed since the question of the right to health had been addressed for the first time, and two major factors had come to light: the ever-increasing gap between rich and poor, on the one hand, and the dichotomy between State responsibility and private-sector capacity, on the other. Without politicizing the debate, it should be clearly understood that the purpose of the draft general comment was to reinforce the responsibility of the State, including its obligation to heighten private-sector awareness of the need to protect the right to health of the destitute.

25. UNESCO, for its part, fully concurred with the Committee's view that health was a fundamental right of the human being and, at the same time, a sine qua non for the exercise of other rights. Economic, social and cultural rights were in fact indivisible, and it was impossible to conceive of the right to health without reference to all other rights. UNESCO also deemed appropriate the emphasis placed on maternal and child health, reproductive health, non-discrimination against the elderly, the disabled and indigenous peoples, and the gender perspective. That being said, the International Charter of Physical Education and Sport, adopted in 1978 by the General Conference of UNESCO, should be added to paragraph 2 which contained the list of international instruments in which the right to health was recognized.

26. Turning to international obligations, she welcomed the emphasis placed by the Committee on the need for the States parties to pay greater attention to protection of the right to health and to promote a corresponding change in the lending policy, loan agreements and decisions of the international financial institutions in the context of the debt crisis. UNESCO was well placed to speak of international obligations, having spearheaded several global

initiatives, one of the most important being the international debate on bioethics. The Universal Declaration on the Human Genome and Human Rights was one of the results of those initiatives. She urged the Committee and WHO to take part in that debate, given the considerable importance of the issues raised by the right to health. In conclusion, she welcomed the recognition by WHO, under its new leadership, that health was crucial to development and the economy, and that it was above all a human right.

27. Ms. MILLER (United Nations Children's Fund - UNICEF) said she was convinced that the draft general comment under consideration would contribute considerably to highlighting and defining the close link between human rights and public health. She particularly welcomed the emphasis placed on the principles of equity and non-discrimination, especially with regard to access to health care for needy persons and those on the fringes of society. UNICEF encouraged the Committee to hold to its view that the enjoyment of the right to health did not depend solely on State action and that the individual was not merely a passive beneficiary of government policies, programmes and strategies.

28. Where children and adolescents were concerned, she was pleased to note that one paragraph was devoted to them exclusively and that the Convention on the Rights of the Child was referred to directly. However, articles 23 and 24 of that Convention were not the only ones with implications for children's right to health. Consideration should also be given to all the general principles enshrined in the Convention, the most important being without doubt the best interests of the child. That principle had not been explicitly mentioned in the draft, yet it was a key principle which should guide the efforts of States in setting policies and programmes for children. In conclusion, she said that UNICEF was awaiting with interest the adoption of the text of the general comment, which would provide guidance for its day-to-day activities on the ground with a view to improving the health of women and children the world over.

29. Mr. WINDFUHR (Food First - FIAN International) first of all suggested adding to the list of vulnerable groups persons suffering from malnutrition, persons deprived of access to productive resources, persons with unproductive land, and urban squatters. An important place should also be assigned in paragraph 9 of the draft general comment to ideas relating to the right to safe food, the right to a healthy environment, and the right to safe working conditions, all essential components of the right to health.

30. Regarding the right to health, FIAN accorded particular attention to the obligation to *protect*, which required States to adopt legislation designed to regulate a great many determinants of health, including the quality of food and food additives. With respect to the three levels of obligations - the obligations to *respect*, *protect* and *fulfil* - FIAN recommended that it should be clearly stated in paragraph 18 that the obligation to *promote* formed an integral part of the obligation to *fulfil*. Inasmuch as human rights were indissociable and indivisible, no distinction should be drawn between economic, social and cultural rights on the one hand, and civil and political rights on the other. FIAN also considered paragraph 13 to be too limited in scope, and suggested spelling out the obligations binding with immediate effect, i.e. all those that either did not necessitate mobilizing resources, or were linked to the obligation to *respect* (regulation and legislation). Lastly, in connection with the obligation to *protect* and *fulfil*, a minimum requirement should be defined, to be guaranteed by States under all circumstances, leaving no room for interpretation of the Covenant.

31. On the question of international obligations binding on States under article 12 of the International Covenant on Economic, Social and Cultural Rights, FIAN could find no reference to multinational corporations in paragraph 46 of the draft. It therefore proposed the addition of two paragraphs: the first would require States to adopt national legislation that would prohibit their own multinationals or foreign multinational corporations operating on their territory from acting in a manner that endangered the health of the local population, while the second would oblige States parties to regulate the conduct of multinationals operating abroad, which came under their jurisdiction. On the subject of the international obligations incumbent on States parties, FIAN proposed amending the text of the draft general comment so as explicitly to prohibit States from exporting foodstuffs and toxic waste that could pose a health risk to the population of receiving countries. States should thus guarantee that there was no risk of their foreign policy impeding the exercise of the right to health by the populations of other countries. FIAN considered that the international financial institutions should be required to ensure that negotiations in respect of loan policies and programmes did not prevent States from fulfilling the obligations imposed on them by the Covenant. Although the obligations of those institutions were spelled out in paragraph 50, it would be advisable to add a paragraph requiring them to display responsibility and transparency in that regard. As far as framework legislation was concerned, FIAN proposed that national strategies should be accompanied by a law on the protection of consumers and citizens that would safeguard them against the toxic substances referred to earlier.

32. Lastly, FIAN suggested that indicators other than those mentioned in paragraph 30 of the draft should be established in order to evaluate shortcomings and measure the progress made. The new indicators would serve to determine the causes of violations of the right to health, such as a breach on the part of a State.

33. Mr. KOTHARI (Habitat International Coalition) observed that matters relating to housing, property rights and displacements, which were in his organization's remit, were given satisfactory coverage in the draft general comment, although they should have been the subject of a separate section. He pointed out, however, that nearly 1 billion persons were currently living an uncertain existence which placed their health and lives in jeopardy. Moreover, there was every indication that that situation, closely linked to poverty, might well grow worse. Overpopulated human settlements were often situated in earthquake or flood-prone areas or close to factories emitting toxic fumes. It was difficult to assess the gravity of the situation - the number of persons affected, sanitation and housing conditions and so forth - given the lack of relevant statistics. For that reason, Habitat International Coalition thought that the obligation of regular monitoring of the situation should be included in the draft general comment.

34. It should also be stressed that armed conflict was not the sole cause of displacements and forced evictions: those situations were also exacerbated by development projects. Populations at risk lived a very uncertain existence, which took a heavy toll on their mental and physical health. There was evidence to show that the living conditions of displaced persons had both short-term and long-term effects on their health and nutrition, and steps should be taken to help them adapt to their new environment.

35. Privatization was also at the root of many problems: water supply and sewerage were increasingly becoming chargeable services and the poor could not afford them. Such practices ran counter to the principles set forth in the Covenant.

36. In 1989, WHO had published a set of Health and Housing Principles, which stated that housing was the environmental factor most frequently associated with conditions for disease in epidemiological analyses. In other words, inadequate housing was invariably associated with higher mortality and morbidity rates. The connection between poverty and housing was increasingly evident and Habitat International Coalition suggested that it be accorded its rightful place in the draft general comment. He shared the FIAN representative's view of globalization: structural readjustment policies had had negative repercussions on the health situation of countries that had adopted them, as was shown by the re-emergence of previously eradicated diseases, such as cholera. It was therefore necessary to establish international cooperation since certain States were unable to fulfil their obligations in that regard, and consequently to step up development assistance with a new mechanism for international solidarity, without which no progress could be made in the field of health. What was required was not just the establishment of a safety net, but the structured drafting of laws and policies.

37. Mr. SCHECHLA (Habitat International Coalition) suggested that the draft general comment should take into account the link between the right to health and water. He called for the establishment of international cooperation and solidarity that would guarantee water quality and availability, key elements of the right to health. States should also be required to take steps to combat the causes and effects of waterborne diseases and pollutants, bearing in mind the fact that such health threats took no account of borders and that if States did not fulfil their obligations under the Covenant, they would incur international responsibility.

38. States also had national obligations in that field, especially the obligation to *respect*, *protect* and *fulfil* the right to health. They must therefore ensure that water was accessible, of the highest possible quality, and equitably distributed, including to communities that had most need of it. To that end, they must take the necessary legal and administrative measures, progressively enhance infrastructures, and avail themselves of the new technologies. He stressed the importance attached by the human rights community to the principles and concepts relating to the fulfilment of the right of access to potable water, which had been taken into account in the Declaration on the Right to Development, in the Sub-Commission's resolution 1998/7 on the promotion of the realization of the right to drinking water supply and sanitation services, and at the United Nations Water Conference.

39. Mr. HAVARD (Commonwealth Medical Association) said that his association was working on strengthening health services in Commonwealth countries in order to improve the health of vulnerable and disadvantaged groups in member countries. He suggested adding to paragraph 10 of the draft the concepts of confidentiality and respect for the dignity of patients, which were both essential to the proper functioning of health services. Medical records were important to the establishment of diagnoses and must be made available to doctors. If assured that what they told their doctors was confidential, patients would be more inclined to be truthful.

It should also be noted that domestic legislation governing health-care services was frequently at variance with the international human rights obligations undertaken by States. States parties should bring that fact to the attention of the drafters of national deontological codes in order to avoid any conflict between domestic legislation and international law. National medical associations could also usefully be given additional powers, since they were undoubtedly in a very good position to detect any breach of the obligations undertaken by States in the health field. The Commonwealth Medical Association organized training courses to promote awareness of health-related human rights among doctors. States should also seek more assistance from national medical associations, for example, in order to implement the Committee's concluding observations within their fields of competence.

The meeting rose at 12.55 p.m.